Maryland CANCER FUND

Cancer Treatment Application

PLEASE COMPLETE ALL AREAS OF THE APPLICATION, Pages 1-3
(If some areas do not apply, please mark "not applicable" or "N/A")

Instructions:

PAGE 1: **RESIDENCY ELIGIBILITY** – The patient must provide proof of Maryland residency for 6 months prior to the application date. **Please provide a copy of ONE of the following documents displaying patient's name AND current home address:**

- Maryland Driver's License
- Maryland State Identification Card
- Lease or Rental Agreement
- Property Tax Bill
- Motor Vehicle Registration
- Paycheck or Stub with Full Name and Home Address
- Utility Bill
- Voter Registration Card
- W-2 Statement (issued not more than 12 months ago)

HEALTH INSURANCE– The patient **may** have any health insurance at the time of application and **may** remain insured during the time of service delivery.

PAGE 2: **ANNUAL FAMILY INCOME** – The patient must have an annual family income of not more than 250 percent of the federal poverty guidelines. Please list the total amount received from all sources of income before taxes are withheld.

FINANCIAL ELIGIBILITY

Please provide a copy of ONE of the following documents displaying patient's name AND current home address:

- **Most Recent Pay Stubs** – Must be for two pays in a row or two pays in the same month
- **Most recent income tax return**
- **Most recent W-2 form**
- **Social Security Entitlement Letter** – The Social Security Administration sends this by mail each January. It lists the amount the patient will receive each month.
- **Notarized Statement** – If the patient is not working, this statement should state that the patient is **not** working and does **not** have **any** income, or that the patient has not had any income in the past 6 months. This is a legal document and must be stamped and signed by a notary public. (See sample patient's statement DHMH Form 4685).

PAGE 3: **PATIENT AGREEMENT** – Please read carefully because the application is a legal document. The patient's signature indicates: (1) the statements that the patient made are true; (2) the MCF has the patient's permission to verify the patient's information provided; and (3) the organization applying on behalf of the patient has the patient's permission to release information regarding the patient's medical, financial, and insurance information to in the MCF.

INFORMATION CONTAINED IN THIS APPLICATION IS CONFIDENTIAL

Maryland Cancer Fund
Cancer Treatment Application
(Page 1 of 3)

PATIENT INFORMATION (Please type or print clearly)

Name: _____ _____ _____
Last First MI

Date of Birth: ☐☐/☐☐/☐☐☐☐
MM DD YYYY

Sex: ☐ Male ☐ Female

Marital: ☐ Separated ☐ Divorced ☐ Married ☐ Single/Never Married ☐ Widowed

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Check all that apply:

Race: ☐ White ☐ Black or African American ☐ Asian ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐ Other (Specify) _____

Patient Currently Employed: ☐ Yes ☐ No
If yes, place of employment: _____
If employed, how long? _____
Spouse Employed: ☐ Yes ☐ No
If yes, place of employment: _____
If employed, how long? _____

Home Address: _____
Number, Street / P.O.Box
_____

_____ _____ _____ _____
City/Town State Zip Code County of Residence

Maryland Resident: ☐ Yes ☐ No

Home Phone: ☐☐☐/☐☐☐/☐☐☐☐
Work Phone: ☐☐☐/☐☐☐/☐☐☐☐ **Ext:** ☐☐☐☐
Cell Phone: ☐☐☐/☐☐☐/☐☐☐☐ **E-Mail:** _____

EMERGENCY CONTACT

Name: _____ _____ **Phone:** ☐☐☐/☐☐☐/☐☐☐☐
Last First

Address: _____

Relationship to Patient: ☐ Spouse ☐ Parent ☐ Child ☐ Other (Specify): _____

Contact Person for Organization Applying:

Name: _____ _____ **Phone:** ☐☐☐/☐☐☐/☐☐☐☐
First Last

HEALTH INSURANCE

Do you have any health insurance? ☐ Yes: ☐ No

If Yes, then list carrier_____

ANNUAL FAMILY INCOME: The total received per year from all sources of income before taxes are withheld.

	INCOME (Please indicate week, month or year)				FOR OFFICE USE ONLY **DOCUMENTATION**
Patient Income (Includes Social Security and any other retirement benefits)	$.	☐ Week ☐ Month ☐ Year	Yearly Total: $.		☐Yes ☐No ☐N/A Initial: _____
Spouse's Income (Includes Social Security and any other retirement benefits)	$.	☐ Week ☐ Month ☐ Year	Yearly Total: $.		☐Yes ☐No ☐N/A Initial: _____
Parents' Income (If patient is a dependent child on parents' income tax return)	$.	☐ Week ☐ Month ☐ Year	Yearly Total: $.		☐Yes ☐No ☐N/A Initial: _____
Child Support	$.	☐ Week ☐ Month ☐ Year	Yearly Total: $.		☐Yes ☐No ☐N/A Initial: _____
Foster Child Supplement (If child(ren) counted in household composition)	$.	☐ Week ☐ Month ☐ Year	Yearly Total: $.		☐Yes ☐No ☐N/A Initial: _____
Unemployment Insurance ☐patient ☐spouse ☐parent	$.	☐ Week ☐ Month ☐ Year	Yearly Total: $.	**Start Date:** **End Date:**	☐Yes ☐No ☐N/A Initial: _____
Workman's Compensation ☐patient ☐spouse ☐parent	$.	☐ Week ☐ Month ☐ Year	Yearly Total: $.	**Start Date:** **End Date:**	☐Yes ☐No ☐N/A Initial: _____
Social Security Disability Insurance ☐dependent child ☐patient ☐spouse ☐parent	$.	☐ Week ☐ Month ☐ Year	Yearly Total: $.		☐Yes ☐No ☐N/A Initial: _____
Alimony ☐patient ☐spouse ☐parent	$.	☐ Week ☐ Month ☐ Year	Yearly Total: $.		☐Yes ☐No ☐N/A Initial: _____
TOTAL ANNUAL FAMILY INCOME			$.		

FINANCIAL ELIGIBILITY

To determine your financial eligibility for this program, we need to collect information regarding household composition and family-income. PROOF OF INCOME MUST BE ATTACHED – (Your most recent Income Tax Return is preferred. Otherwise, provide your W-2 Forms, Social Security Entitlement Letter, a minimum of 2 pay stubs in a row or 2 pays in the same month, or a notarized letter stating "No Income and No Employment" can be substituted).

FAMILY COMPOSITION

Please list the names and ages of all family members within the houshold and indicate their relationship to the patient. Include: patient, spouse, financially dependent child(ren) and all other dependents listed on your income tax return form. If the patient is a child, include: child, parent, foster parent, or guardian, sibling(s).

LAST NAME	FIRST NAME	AGE	RELATIONSHIP TO PATIENT
1.			
2.			
3.			
4.			
5.			
If there are more than five (5) family members within the household, please continue the list on a separate sheet and attach.			

Total number of people in family, including patient: ☐

PATIENT AGREEMENT

(Please read carefully before signing)

I certify that all the information on this form is true, correct and complete. I understand that any false statements would subject me to penalties under State law and would result in a denial of grant eligibility.

I authorize the Maryland Department of Health and Mental Hygiene, Center for Cancer Surveillance and Control, Maryland Cancer Fund (MCF) to verify any information provided by me on this form. I will provide proof of any information on this form as required by the MCF.

I agree to allow the _____
Name of Organization

to release the medical/financial/insurance information regarding my cancer treatment and the Maryland Department of Health and Mental Hygiene that administers the Maryland Cancer Fund.

_____
Signature of Patient or Parent/Guardian

_____
Name of Contact Person for Organization Applying
(Please Print or Type)

_____
Name of Patient
(Please Print or Type)

_____
Address of Contact Person
(Please Print or Type)

_____
Date of Application

_____
Office Phone of Contact Person

RETURN COMPLETED MCF APPLICATION TO:

Maryland Cancer Fund
Maryland Department of Health and Mental Hygiene
201West Preston Street, Room 306
Baltimore, Maryland 21201

For questions, please call (410) 767-6213

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